## State of New Jersey Vehicle Accident Report

### Print or Type only
- **State of New Jersey**
- **Vehicle Accident Report**
- **TYPE OF STATE VEHICLE**
  - □ Subcompact
  - □ Compact
  - □ Passenger cars/station wagons
  - □ Vans used for transporting people
  - □ All other Vans
  - □ Utility Vehicles & pick up trucks
  - □ Light Trucks - Wt. 5,000 - 10,000 Lbs.
  - □ Medium Trucks - Wt. 10,001 - 20,000 Lbs.
  - □ Heavy Trucks - Wt. 20,001 - 45,000 Lbs.
  - □ Extra Heavy Trucks - Wt. over 45,000 Lbs.
  - □ Misc Equipment *
  - **Fire engines, ambulances, etc.**

### Environmental Conditions
- **Weather**
  - □ Clear
  - □ Rain
  - □ Snow
  - □ Fog
  - □ Other
- **Surface**
  - □ Dry
  - □ Wet
  - □ Snow
  - □ Icy
  - □ Other
- **Light Condition**
  - □ Daylight
  - □ Dawn or Dusk
  - □ Dark (Street lights on)
  - □ Dark (Street lights off)
  - □ Dark (No Lights)
- **Collision Involved With**
  - □ Pedestrian
  - □ Other motor veh.
  - □ Overturned
  - □ Pedalcycle
  - □ Moped or Motorcycle
  - □ Animal
  - □ Fixed Object
  - □ Other object

### Defensive Driving within the last 36 Months?
- □ Yes
- □ No
- **Date** / / **

### Information in this area to be Provided by Employee's Supervisor.

## State Driver Injuries
- □ 0. First aid or other non recordable incident
- □ 1. Medical Treatment
- □ 2. Medical Treatment - Employee transferred
- □ 3. Medical Treatment - Employee terminated
- □ 4. Loss of consciousness - no medical treatment
- □ 5. Lost work day case
- □ 6. Lost work day case - Employee transferred
- □ 7. Lost work day case - Employee terminated
- □ 8. Fatality

### Vehicle
- □ 1. Normal job related operation
- □ 2. Commuting to or from home and place of work (temp. or permanent)
- □ 3. Commuting to or from breakfast, lunch, or dinner and place of work
- □ 4. Other (define)

**DOT use only - 5. Striping 6. Sanding 7. Snow Plowing 8. Road or Bridge Maint.**


### Persons Injured
- □ 1. Name & Address
- □ 2. Name & Address
- □ 3. Name & Address

### Estimated Workdays off job
- □ Actual

**Count work days (consecutive or not). Employee would have worked, but could not because of occupational injury or illness. Don't count day of injury, holidays or normal days off.**

### Workdays on Modified Job
- □ Estimated
- □ Actual

**Enter total of 1. Days assigned to temporary job. 2. Part time days on regular job. 3. Days on regular job but unable to perform all normally connected duties.**
DESCRIPTION OF ACCIDENT
PRINT CLEARLY!

Refer to vehicles by number - Give direction and approximate speed of each vehicle. Include description of property damage other than vehicle damage.

INDICATE INITIAL IMPACT DAMAGE
FRONT
REAR
AREAS DAMAGED
1. Underr. Damage
2. Overturned
3. Totalled
4. None or Unknown
5. Other

ADD SUPPLEMENTAL SHEETS AS NECESSARY

NAME: ___________________________ ADDRESS: ___________________________
TELEPHONE NUMBER: ___________________________

SIGNATURE OF STATE DRIVER COMPLETING THE FORM: ___________________________
DATE: ___________________________
TITLE & ORGANIZATION: ___________________________
TELEPHONE NUMBER: ___________________________

NAME: ___________________________ ADDRESS: ___________________________
TELEPHONE NUMBER: ___________________________

SIGNATURE OF DRIVER'S SUPERVISOR: ___________________________
DATE: ___________________________
TITLE: ___________________________
TELEPHONE NUMBER: ___________________________

NAME: ___________________________ ADDRESS: ___________________________
TELEPHONE NUMBER: ___________________________

SIGNATURE OF FLEET LIASON OFFICER: ___________________________
DATE: ___________________________
TITLE: ___________________________
TELEPHONE NUMBER: ___________________________

POLICE REPORT TO BE FORWARDED AS SOON AS POSSIBLE